

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6702

CERTIFICATE OF DEATH

06630

Reg. Dist. No. 336

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Delmar</u>		LENGTH OF STAY (in this place) <u>38 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Delmar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>110 East Street</u>				STREET ADDRESS (If rural give location) <u>110 East Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Chester Washington Baker</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 16, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>June 27, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Gumboro, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter William Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-05-9264</u>		17. INFORMANT & ADDRESS <u>Iona Baker, Delmar, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 54</u> <u>June 16</u> <u>1956</u> , that I last saw the deceased alive on <u>June 15</u> <u>1956</u> , and that death occurred at <u>5:45</u> <u>P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>Delmar, Md.</u> DATE SIGNED <u>6-16-56</u>							
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Byrd</u>		LOCATION (City, town, or county) (State) <u>Mears, Va.</u>	
24. REC'D BY REGISTRAR DATE <u>6-19-56</u>		REGISTRAR'S SIGNATURE <u>Harry C. Hudson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar Del</u>		ADDRESS	

06230

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

0702

DEPARTMENT OF HEALTH

SAINT JOHN'S HOSPITAL

BUREAU V. 2

JUN 19 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

86631

6793

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>WICOMICO</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA SPRINGS</u> LENGTH OF STAY (in this place) <u>3 YRS</u> TOWN <u>MARDELA SPRINGS</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>WICOMICO</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA SPRINGS</u> TOWN <u>MARDELA SPRINGS</u> STREET ADDRESS (If rural give location) <u>BRIDGE ST</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM WASHINGTON BENNETT</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>JUNE 4 1956</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 21 1874</u>
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>DORCHESTER VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. BENNETT</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA BRADLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>MAPLE SHADE CONVALESCENT HOME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 490X IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL HEMORRHAGE</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CHRONIC MYOCARDITIS</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>5 WEEKS</u>	
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>NONE</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>NONE</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE 17 1956</u> to <u>JUNE 4 1956</u> , that I last saw the deceased alive on <u>JUNE 3 1956</u> , and that death occurred at <u>9:35 PM</u> from the causes and on the date stated above. SIGNATURE <u>W. E. Aptz, M.D.</u> ADDRESS (Street, city, town, state) <u>MARDELA SPRINGS MARYLAND</u> DATE SIGNED <u>6/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> DATE THEREOF <u>JUNE 6 1956</u> NAME OF CEMETERY OR CREMATORY <u>MARDELA CEMETERY</u> LOCATION (City, town, or county) (State) <u>MARDELA MARYLAND</u>			
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u> REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co. Salisbury Md.</u> ADDRESS	
DATE <u>JUN 6 1956</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

RECEIVED

BUREAU V. S.

JUN 6 1956

RECEIVED

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6646

CERTIFICATE OF DEATH

07676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN IB <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Anna</u> Last <u>Benton</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1885</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Deal Island, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE B. HORNER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET HITCHENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Deal Island</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Sept. 26, 1955</u> , to <u>June 25, 1956</u> , that I last saw the deceased alive on <u>June 25, 1956</u> , and that death occurred at <u>9:10A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>				DATE SIGNED <u>6/25/56</u>			
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Deal Island Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Webster</u>		ADDRESS <u>Deal Island Md</u>		24a. REC'D BY REGISTRAR <u>DATE 6/26/56</u>	24b. REGISTRAR'S SIGNATURE <u>John J. [illegible]</u> <u>May 27. [illegible]</u>		

CERTIFICATE OF DEATH

9510

BUREAU V. S.

JUL 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6647

CERTIFICATE OF DEATH

Reg. Dist. No.

06632

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 18 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle BOUNDS Last BOUNDS				4. DATE OF DEATH Month JUNE Day 17 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1876	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired produce broker				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel D. Bounds				14. MOTHER'S MAIDEN NAME Sally Noble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Beulah Bounds Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 332 X (c) 7 days				INTERVAL BETWEEN ONSET AND DEATH 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 1956 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury, Md.				20g. (County) Salisbury, Md.		20h. (State) Salisbury, Md.	
21. I certify that I attended the deceased from 6-17 , 19 56 , to 6-17 , 19 56 , that I last saw the deceased alive on 6-17 , 19 56 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William R. Ellis, M.D.				ADDRESS (Street, city or town, state) Salisbury, Md.			
DATE SIGNED 6-17-56							
PHYSICIAN'S NAME (Type) William R. Ellis							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-19-1956		22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Vernon, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis R. Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR Mary W. Hellonay	
				DATE 6-20-56		24b. REGISTRAR'S SIGNATURE Mary W. Hellonay	

CERTIFICATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

NAME OF FATHER

NO.

NO.

NO.

BUREAU V. S.

JUN 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6648 CERTIFICATE OF DEATH

66633

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS Spring Hill Rd.,	
3. NAME OF DECEASED (Type or print) First FRANK Middle THOMAS Last BRITTINGHAM		4. DATE OF DEATH Month 6 Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1877
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Telephone	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME B en Brittingham		14. MOTHER'S MAIDEN NAME Mrs. Ella M. Lavinia Dishroom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no.	
17. INFORMANT Mrs. Ella M. Brittingham, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 Atherosclerotic gangrene left leg DUE TO Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) yes DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-16-56 , to 6-24-56 , that I last saw the deceased alive on 6-24-56 , and that death occurred at Salisbury, Md. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry A. Brisle M.D.		ADDRESS (Street, city or town, state) Medical Center DATE SIGNED 6-25-56	
PHYSICIAN'S NAME (Type) Dr. Henry Brisle, Medical Center Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/56	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Salisbury, Maryland	
24a. REC'D BY REGISTRAR DATE 6-26-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

Norman T. Baker

2

JUN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6649 CERTIFICATE OF DEATH

06634

Reg. Dist. No. 382

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS R.D. # 1 (Union Rd.)			
3. NAME OF DECEASED (Type or print) First MORRIS Middle WILLIAM Last BROWN				4. DATE OF DEATH Month JUNE Day 14 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1908	9. AGE (In years last birthday) yrs. 48	IF UNDER 1 YEAR Months 2 Days 25	IF UNDER 24 HRS. Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) R.D. # 1 Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Thomas Brown				14. MOTHER'S MAIDEN NAME Hannah T. Farlow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs. Bessie J. Brown (Wife) Address R.D. # 1 (Union Rd) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon 1.53X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mr June 14 , 19 56 to June 14 , 19 56 , that I last saw the deceased alive on June 14 , 19 56 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A Insley M.D.				ADDRESS (Street, city or town, state) 116 E. Main St (Office) DATE SIGNED June 15 1956			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE May W. Holloway	



8-1-1944

NPI



6650

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Bishop</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Peninsula Hospital</u>				d. STREET ADDRESS <u>Bishop</u>			
3. NAME OF DECEASED (Type or print) <u>Stanley</u> First Middle Last <u>Bunting</u>				4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) yrs. <u>1 mo.</u>		11. PLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Madison Bunting</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Selby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Madison Bunting Bishop Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>							
154.4 DUE TO (b) <u>Congen. Heart Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Transposition of Great Vessels</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>June 26</u> , 19 <u>56</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris A. Lambdin</u>				ADDRESS (Street, city or town, state) <u>707 Camden Ave</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Lambdin</u>				DATE SIGNED <u>Salisbury Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>190.F</u>		22d. LOCATION (City, town, or county) (State) <u>Bishop Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Selby</u>				ADDRESS <u>Salisbury</u>		24a. REC'D BY REGISTRAR <u>6-30-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6651 CERTIFICATE OF DEATH

66636
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Peninsula General Hospital</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> d. STREET ADDRESS _____ • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CANNON</u>		4. DATE OF DEATH Month Day Year <u>June 19-1956</u>					
5. SEX <u>Female colored</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 19-1956</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min <u>2</u> <u>17</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME _____			14. MOTHER'S MAIDEN NAME <u>Marybelle CANNON</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Marybelle Cannon-Fruitland Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I attended the deceased from <u>June 19, 1956</u> , to <u>June 19, 1956</u> that I last saw the deceased alive on <u>19 June 1956</u> , and that death occurred at <u>3:58 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris C. Lambdin</u>		ADDRESS (Street, city or town, state) <u>707 Camden, Salisbury Md.</u>					
DATE SIGNED <u>6-20-56</u>		NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>6/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital Salisbury Md.</u>			
22d. LOCATION (City, town, or county) _____		(State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u>			
24a. REC'D BY REGISTRAR <u>DATE 6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Marybelle Holliday</u>					

BUREAU V. S.

JUN 22 19

RECEIVED

6652

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <u>DELAWARE</u> b COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLSBORO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Main ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amy Ellen Clouser</u>				4. DATE OF DEATH Month Day Year <u>June 27 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 8, 1986</u>	
9. AGE (In years last birthday) <u>70</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Samuel Kenney</u>		14. MOTHER'S MAIDEN NAME <u>Martha Calloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Clarence Clouser Millsboro, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renovascular</u> <u>585X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Cholelithiasis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>8-9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/20/56</u> , 1956, to <u>6/27/56</u> , 1956, that I last saw the deceased alive on <u>6/27/56</u> , 1956, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B Long</u> M.D.				ADDRESS (Street, city or town, state) <u>Med Center Salisbury Md</u> DATE SIGNED <u>6/29/56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James</u>				ADDRESS <u>Millsboro, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>7-2-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Calloway</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

T FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06638

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R F D # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mae</u> Last <u>Custis</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 29, 1954</u>		9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Whaleysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Warner Custis</u>				14. MOTHER'S MAIDEN NAME <u>Martha Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Martha Custis, Selbyville, Del.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child playing under car that backed over it.</u>					
20c. TIME OF INJURY Hour <u>2P</u> o. m. <u>6 23</u> p. m. <u>19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Yard of home.</u>		20f. (City or town) <u>Selbyville</u> (County) <u>Sumner</u> (State) <u>Del.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>6-26-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-26-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mission Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hing H. Hatter</u>				ADDRESS <u>Broomfield, Md.</u>		24a. REC'D BY REGISTRAR <u>6-26-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary M. Holloman</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 28 1956

BUREAU A. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6654

CERTIFICATE OF DEATH

Reg. Dist. No.

100039
06639

352

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 HOURS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R# 3 Box 301</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DUFFY</u>				4. DATE OF DEATH Month Day Year <u>JUNE 23 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 22, 1956</u>	
9. AGE (In years lost birthday) yrs. <u>3</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LOUIS SANDERS DUFFY</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Elsie DENNIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>1956</u> , that I lost saw the deceased alive on <u>1956</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town; state) DATE SIGNED ACTUAL SIGNATURE <u>Morris C. Lambdin</u> M.D. <u>Salisbury, Md.</u> NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>623-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

BUREAU OF A. R.

100-100

100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6794 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

186640

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown drawbridge</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finchville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Clifford</u> Last <u>Fieldner</u>				4. DATE OF DEATH Month <u>6-16</u> Day <u>19</u> Year <u>56</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1954</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clifford Fielder</u>						14. MOTHER'S MAIDEN NAME <u>Goldie Mae Quails</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Clifford Fielder, Federalsburg, Md., R.F.D.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>824X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that ran through barricade off open drawbridge.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9 P</u> a. m. <u>6-16</u> p. m. <u>19 56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Drawbridge</u>		20f. (City or town) <u>Sharptown</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined cause</u> <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.												CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-18-56</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federalsburg Col. Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>												24a. REC'D BY REGISTRAR <u>6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IN A 100000

100000

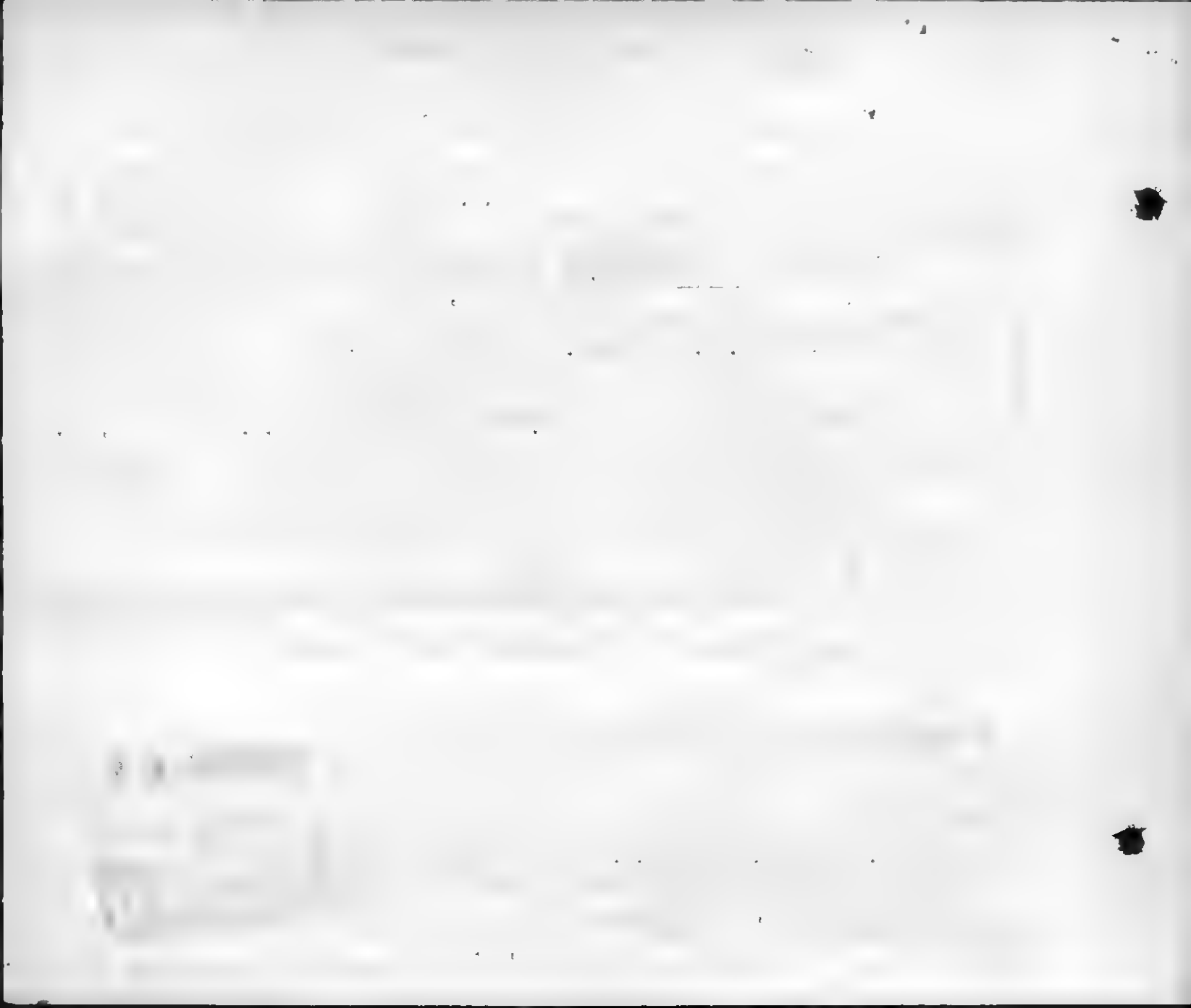
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6655
CERTIFICATE OF DEATH

06641

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.D. # 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>Johnathan</u> Last <u>Figgs</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1896</u>		9. AGE (In years last birthday) yrs <u>59</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Box Maker (Employee)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>H. & H. Poultry Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Melson Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Joseph Figgs</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Dorothy Figgs (Wife)</u> Address <u>R.D. # 2 Bishop, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic coronary thrombosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>6-16</u> , 19 <u>56</u> , and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. R. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u> <u>6-16-56</u> PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis M.D.</u> Medical Center - Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME- SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>6 19 56</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6. Film 61

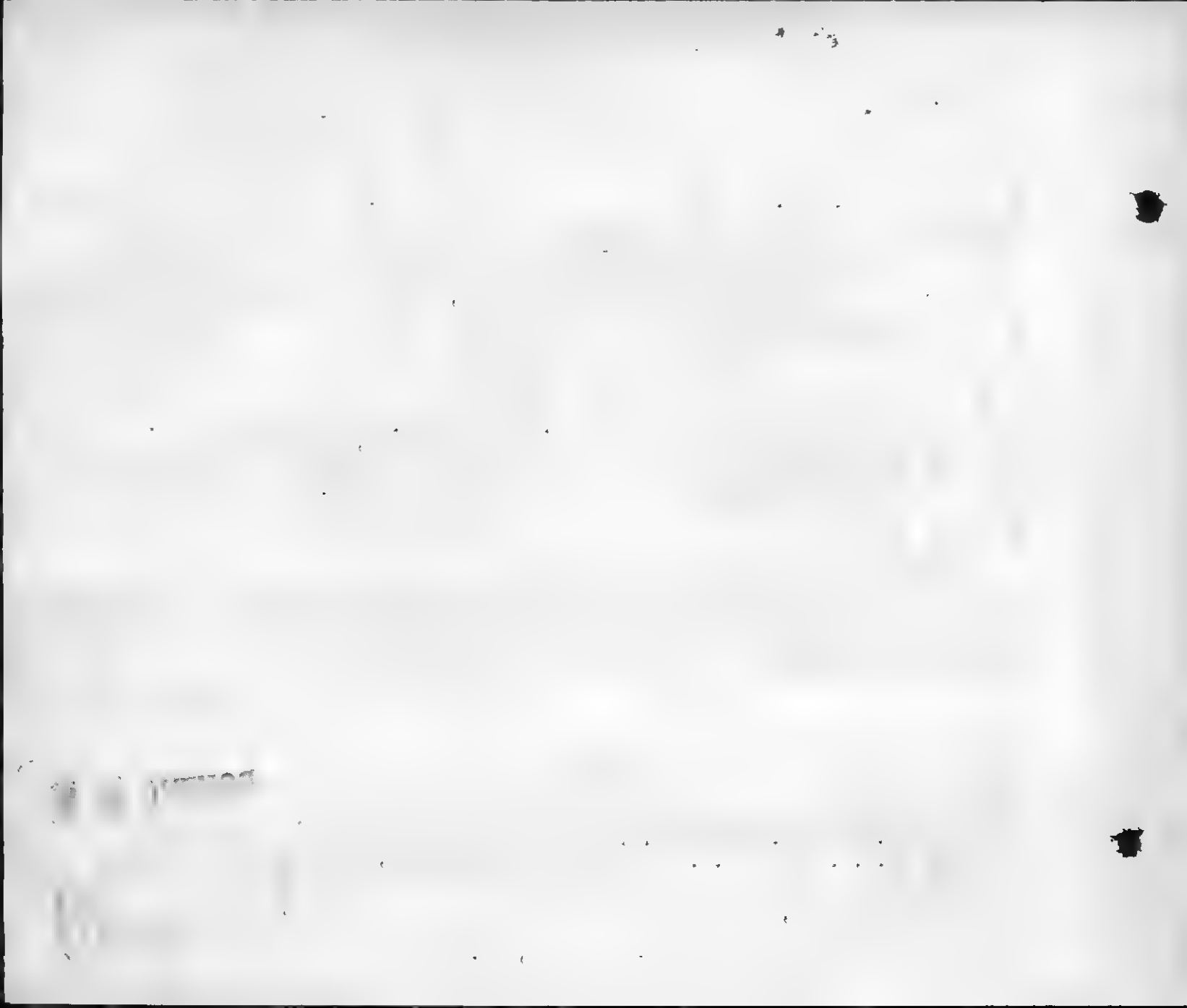
66642

6656

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pen. Gen. Hospital</u>		d. STREET ADDRESS <u>807 S. Division St</u>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>MARIE</u> Last <u>FINK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1893</u>
9. AGE (In years last birthday) yrs <u>62</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Orange New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Flanagan</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Marie McDevitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Mr. Alexander S. Fink (Husband)</u>	
17. INFORMANT <u>Mr. Alexander S. Fink (Husband)</u>		Address <u>807 S. Division St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Internal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>56</u> , to <u>6/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Andrew C. Mitchell</u> Dr. Andrew C. Mitchell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>211 Maryland Ave. (Office) June 25, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Dr. O. J. Burton M.D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>June 28, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6657

CERTIFICATE OF DEATH

Reg. Dist. No.

06643

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS Main			
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Fletcher				4. DATE OF DEATH Month June Day 23 Year 1956			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1910	9. AGE (In years last birthday) 45 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sharptown, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl H. Bennett				14. MOTHER'S MAIDEN NAME Clara Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 220-26-3511		17. INFORMANT Address Elva Fletcher, Sharptown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix Stage IV Inadeq TV 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of left femoral artery DUE TO (c) Metastatic Carcinoma to bladder							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/17 1955 , to 6/23 1956 , that I last saw the deceased alive on 6/23 1956 , and that death occurred at 8:00 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE William S. Womack				ADDRESS (Street, city or town, state) DATE SIGNED 706 Camden Ave.			
PHYSICIAN'S NAME (Type) William S. Womack				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-56		22c. NAME OF CEMETERY OR CREMATORY Fireman		22d. LOCATION (City, town, or county) (State) Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Mangel - Sharptown, Md				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary H. Feltway	

BUREAU A. J.

JUN 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6658
CERTIFICATE OF DEATH

66644

Reg. Dist. No. 232

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>4 Wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR</u> <u>GARRISON</u>				4. DATE OF DEATH Month Day Year <u>JUNE 15</u> <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 10, 1860</u>	
9. AGE (In years last birthday) <u>96</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. <u>3</u> <u>3</u>		IF UNDER 24 HRS <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Thomas Spencer Garrison</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs. Maude Garrison, Tyaskin, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-19</u> , 19 <u>56</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>W. S. Ellis, Jr.</u> M.D. <u>Salisbury, Md. 6-16-56</u>							
ACTUAL SIGNATURE <u>W. S. Ellis, Jr.</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Town Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. S. Messick</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary R. Hollaway</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06645

6659

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. LENGTH OF STAY IN 1b <u>5yr. 2mo. 3 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City, Maryland</u>				d. STREET ADDRESS <u>301 Clarke Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Agnes GIBSON</u>				4. DATE OF DEATH Month Day Year <u>June 20 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23, 1878</u>	
9. AGE (In years last birthday) yrs <u>77</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Hardesty</u>				14. MOTHER'S MAIDEN NAME <u>Martha A. Poor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>unk</u>		17. INFORMANT <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of femoral neck</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Apr. 17</u> , 19 <u>51</u> , to <u>June 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>56</u> , and that death occurred at <u>12:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Gore, M.D.</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>			
DATE SIGNED <u>6/20/56</u>							
PHYSICIAN'S NAME (Type) <u>Robert J. Gore, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 24/56</u>		<u>Salisbury M. E. Cemetery</u>		<u>Pocomoke Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson, Pocomoke Md.</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollman</u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 28 1955

RECEIVED

6660

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>WICOMICO</u>	MARYLAND	STATE <u>VIRGINIA</u>	COUNTY <u>ACCORACK</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OAK HALL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverside Convalescent</u>	Home	STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>L. FRANK GLADDING</u>		DATE OF DEATH <u>JUNE 14 1956</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Sept. 21, 1872</u>
9. AGE last birthday: <u>83 yrs.</u>		10. IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Geo. W. GLADDING</u>		14. MOTHER'S MAIDEN NAME: <u>VALLY STOCKELY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>James Gladding Oak Hall, Va</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>16 weeks</u>	
ANTECEDENT CAUSE (B) <u>DUE TO</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension. Arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/15 1955</u> , to <u>6/14 1956</u> , that I last saw the deceased alive on <u>6/14 1956</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Calvin Beardsley</u>		DATE SIGNED <u>6/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 17 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>DOWNINGS</u>		LOCATION (City, town, or county) (State) <u>OAK HALL VA</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-18-56</u>		24. FUNERAL DIRECTOR <u>Mrs. M. A. Shields</u> ADDRESS <u>New Church, Va</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6661

CERTIFICATE OF DEATH

06647

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 501 Anne St.	
3. NAME OF DECEASED (Type or print) First EDNA Middle WHITE Last GOSWELLEN		4. DATE OF DEATH Month JUNE Day 24 Year th 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1894
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Operator) Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY R.D. #1 Salisbury (Wor. Co.) Md USA	
11. BIRTHPLACE (State or foreign country) R.D. #1 Salisbury (Wor. Co.) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence Bates McGrath		14. MOTHER'S MAIDEN NAME Laura Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. W. Ardie Goswollen (Husband)		Address 501 Anne St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal and Cerebral Hemorrhage DUE TO Myeloblastic Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 months DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverticulitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 14, 1956 to June 24, 1956 , that I last saw the deceased alive on June 24, 1956 , and that death occurred at 7:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas C. Hill		ADDRESS (Street, city or town, state) 224 N. Division St. (Office) Salisbury, Maryland	
DATE SIGNED June 15 1956			
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 27, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

RECEIVED

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6662 CERTIFICATE OF DEATH

Reg. Dist. No.

66648
332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMAC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Temperanceville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin Eldridge Gravelly</u>		4. DATE OF DEATH Month Day Year <u>June 3 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30 1900</u> 9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALES</u>	
11. BIRTHPLACE (State or foreign country) <u>AKRON, OH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John L. Gravelly</u>		14. MOTHER'S MAIDEN NAME <u>Theo Eggleston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Evelyn Waples Gravelly</u>		Address <u>Temperanceville, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-29</u> , 19 <u>56</u> , to <u>6-3</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6-3</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard R. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u>		DATE SIGNED <u>6-3-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/5/56</u>	<u>John W. Taylor Memorial</u>	<u>Temperanceville, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Johnson</u>		ADDRESS <u>Particky R.</u>	
24a. REC'D BY REGISTRAR <u>DATE 6-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

IS 'A' 011700

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06649

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		c. LENGTH OF STAY IN 1b Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		e. STREET ADDRESS 506 Truitt St	
3. NAME OF DECEASED (Type or print) First FULTON Middle EVERETT Last GRIFFIN		4. DATE OF DEATH Month JUNE Day 13 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1908
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 0 Days 5	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Employee T.L. Ruark & Co.	
11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Sewell E. Griffin		14. MOTHER'S MAIDEN NAME Anna Mae Holloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W. # 11	
17. INFORMANT Mrs. Flora H. Griffin (wife)		Address 506 Truitt St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.		DATE SIGNED June 15 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 6-18-56	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>507 Camden Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>507 Camden Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Kirk</u> Last <u>Gunby</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1956</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1893</u>		9. AGE (In years last birthday) <u>63</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Louis W. Gunby</u>				14. MOTHER'S MAIDEN NAME <u>Frances Graham</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <input checked="" type="checkbox"/> <u>WW I & II</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph Y. Gunby</u> Address <u>Same</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from, Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.																	
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-25-56</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/25/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burge C. Hill</u> ADDRESS _____						24a. REC'D BY REGISTRAR <u>6-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

JUN 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6665

CERTIFICATE OF DEATH

86651

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Withams.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>Withams.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>HALL</u> Last <u>HALL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 3, 1880</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE OWN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>			
11. BIRTHPLACE (State or foreign country) <u>SANFORD VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>RAYMOND LEWIS</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN PARKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>DARIES T. HALL (Withams, Va.)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, generalized.</u> <u>2000</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retention Cell Infection, intestines</u> DUE TO (c) <u>c. gangrene.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>5-22</u> , 19 <u>56</u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Long</u> M.D.				ADDRESS (Street, city or town, state) <u>Med. Center, Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type)				DATE SIGNED <u>6/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JUNE 17, 1956</u>		<u>DOWNING CEM</u>		<u>OAK HALL, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson, Pocomoke Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 6 19 56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Hollaway</u>	

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06652

6666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 HOURS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>FEDERAL STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HANCOCK</u>				4. DATE OF DEATH Month Day Year <u>JUNE 2 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 2, 1956</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>30</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Arthur Hancock</u>			
14. MOTHER'S MAIDEN NAME <u>Flora Amelia Adkins</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Arthur Hancock, Snow Hill, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to <u>6/2</u> , 19 <u>56</u> , that I lost the deceased alive on <u>6/2/56</u> , 19____, and that death occurred at <u>3:07</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>William C. Morgan M.D. Salisbury, Md.</u> <u>6/2/56</u> PHYSICIAN'S NAME (Type) <u>William C. Morgan, M.D. Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 3-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital, Salisbury, Worcester, Maryland.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 6-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>Marijill Holloman</u>	

BUDELL V. S.

NO. 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										67696
6667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 332
Item 7, Film G200, 1/2 x 2 1/2 in.										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Edgar Adkins Farm</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>McGee</u> Last <u>Hansley</u>					4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>56</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNMARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>		9. AGE (In years and birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>?</u> Days <u>?</u> Hours <u>?</u> Min. <u>?</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>?</u>					14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>?</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Don. Sen Hospital</u> Address <u>?</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage due to stab wound of popliteal artery</u> <u>913.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> hrs.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on butcher knife during a fight.</u>							
20c. TIME OF INJURY Month, Day, Year <u>10</u> p. a. m. <u>6-30-56</u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pocomoke</u> <u>Wicomico</u> <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>			22b. DATE THEREOF <u>6-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burgess Cem</u>			22d. LOCATION (City, town, or county) (State) <u>Pocomoke</u> <u>Wicomico</u> <u>Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Stewart</u>					24a. REC'D BY REGISTRAR DATE <u>7-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

BUREAU V. 3

JUL 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06653

6668

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>J. Roy Hardesty</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1887</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>never employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. P. Hardesty</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. metastases of abdomen</u> DUE TO (b) <u>Ca. of pancreas</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 months</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 29</u> , 19 <u>56</u> , to <u>June 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>56</u> , and that death occurred at <u>12:50P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Juerman</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>6/11/56</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		24a. REC'D BY REGISTRAR <u>6-13-56</u>	
ADDRESS <u>1217 St. Paul Street</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollander</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6669
CERTIFICATE OF DEATH

66654

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Sanitarium		d. STREET ADDRESS State Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nancy First Middle Last Hastings		4. DATE OF DEATH June 8 19 56 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov, 4, 1869
9. AGE (In years birth day) 86 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archielus Hastings		14. MOTHER'S MAIDEN NAME May Rue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Earl Hastings, Salisbury, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months 15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1956 , to June 8 1956 , that I last saw the deceased alive on JUNE 8 1956 , and that death occurred at 12:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D.		ADDRESS (Street, city or town, state) Delmar, Del. DATE SIGNED	
PHYSICIAN'S NAME (Type) Philip A. Insley			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	22b. DATE THEREOF 6-11-56	22c. NAME OF CEMETERY OR REINTERMENT Smith Mills	22d. LOCATION (City, town, or county) (State) Delmar, Del.
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del ADDRESS		24a. REC'D BY REGISTRAR DATE 6-13-56	
		24b. REGISTRAR'S SIGNATURE May J. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

W. A. DAVENPORT

1956 C. N.

1956

Reg. Dist. No. 332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 5 (Glen Rd)		d. STREET ADDRESS R.D.# 5 (Glen Rd) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OLLIE First ATMORE Middle HITCHENS Last		4. DATE OF DEATH JUNE Month 2nd Day 1956 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1891
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refinishing Furniture - Furniture		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (State or foreign country) Nelsons Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Atmore Hitchens		14. MOTHER'S MAIDEN NAME Mahala Maddox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Lillie V. Hitchens (Wife) Address R.D.# 5 (Glen Rd) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma DUE TO Carcinoma of Parotid Gland Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-24 , 19 56 , to 6-2 , 19 56 , that I last saw the deceased alive on 5-24 , 19 56 , and that death occurred at 3:00A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Golden Ave. Salisbury, Maryland DATE SIGNED June 4 1956 ACTUAL SIGNATURE Earl L. Royer M.D. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 4, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE 6-5-56	24b. REGISTRAR'S SIGNATURE James E. Royer

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BUREAU V. S.

1950



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6670

CERTIFICATE OF DEATH

06656

Reg. Dist. No. 360332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 1/2</u> years	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rebecca Elizabeth Hoffman</u>		4. DATE OF DEATH Month Day Year <u>June 8 19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1871</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Bettys Ann Marsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 17</u> , 19 <u>50</u> , to <u>June 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>56</u> , and that death occurred at <u>2:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Deer's Head State Hospital</u> <u>6/8/56</u> ACTUAL SIGNATURE <u>L. V. Maldve, M. D.</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Newman</u>		24a. REC'D BY REGISTRAR DATE <u>6/11/56</u>	
ADDRESS <u>Princess Anne, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Hallaway</u>	

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6671

CERTIFICATE OF DEATH

06657

Reg. Dist. No. 332

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>327 Camden Ave.</u>		d. STREET ADDRESS <u>327 Camden Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HENRY HARVEY HATFIELD HOLDEN</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> th Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1877</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer - Employee of Printing Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William J. Holden</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Silvia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mr. Milton M. Holden (Son)</u> Address <u>Newport, Delaware</u>		18. <u>Mrs. H. Harvey Holden (Wife)</u> <u>327 Camden Ave. Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 9, 1956</u> to <u>June 9, 1956</u> that I last saw the deceased alive on <u>June 9, 1956</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Camden Ave. Salisbury, Maryland</u>	
ACTUAL SIGNATURE <u>Harry Mattax</u> M.D.		DATE SIGNED <u>June 11, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Harry Mattax</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 12, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY MD.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>6-12-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holden</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06658

6672

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 5/13/55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u> <u>Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>Delmar Road, R. F. D. #5</u>			
3. NAME OF DECEASED (Type or Print) <u>Samuel Earl Holt</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 22 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 4, 1879</u>		9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Worked on Boat</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Holt</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Sommers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Deceased on admission to hospital</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
102X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						<u>1 yr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chc Myocarditis.</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 13</u>, 19<u>55</u>, to <u>June 22</u>, 19<u>56</u>, that I last saw the deceased alive on <u>June 22</u>, 19<u>56</u>, and that death occurred at <u>6</u> <u>A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. H. Hurdler</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>6/22/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jun. 24, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Varsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>110 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Salisbury Co Salisbury Md.</u>			
DATE							

JUN 25 1964

JUN 25 1964

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6706

CERTIFICATE OF DEATH

06659

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. LENGTH OF STAY IN 1b 50 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Street				d. STREET ADDRESS Church Street			
3. NAME OF DECEASED (Type or print) First Elfa Middle E. Last Howard				4. DATE OF DEATH Month June Day 11 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 31, 1869	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months 11 Days 11 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Sussex County, Del.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wilson Baker				14. MOTHER'S MAIDEN NAME Augusta Knowles,			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Wilson Howard, Hebron, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hebron				20g. (County) Wicomico		20h. (State) Md.	
21. I certify that I attended the deceased from June 5th, 1956 to June 10th, 1956 that I last saw the deceased alive on June 10th, 1956 and that death occurred at 10:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William E. Smith				ADDRESS (Street, city or town, state) Hebron - Md			
PHYSICIAN'S NAME (Type) W. E. Smith				DATE SIGNED June 11-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-56		22c. NAME OF CEMETERY OR CREMATORY Hebron		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marm Co - Hebron, Md				24a. REC'D BY REGISTRAR DATE 6-14-56		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

100-100000

JUN 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6673

CERTIFICATE OF DEATH

66660

Reg. Dist. No. 323

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 3 yrs				d. STREET ADDRESS 114 Walston Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 114 Walston Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last HYNSON				4. DATE OF DEATH Month June Day 13 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1873	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months 13 Days th Hours 56	IF UNDER 24 HRS. Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Watchman		11. BIRTHPLACE (State or foreign country) Talbot Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Hynson				14. MOTHER'S MAIDEN NAME Roxanna Tarbutton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John P. Hynson (Son) Address 114 Walston Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 1954 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 mon.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 9 P. M. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Feb. 1956 , to 6-13-56 , 19____, that I last saw the deceased alive on 6-13-56 , 19____, and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Maryland DATE SIGNED June 4 1956							
ACTUAL SIGNATURE Lee Lawry M.D.							
PHYSICIAN'S NAME (Type) Dr. Lee Lawry M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16 1956	22c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE Mary W. [Signature]	

E. A. DUFFY

CHRYSLER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06661

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> City <u>Salisbury</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 - 4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Hill Nursing Home</u>		d. STREET ADDRESS <u>1115 Argonne Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Esau</u>		4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1880</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired machinest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Esau S.D. Insley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Dickey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs David Turner Nanticoke, Maryland</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic cardio-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u>gave rise to the underlying cause lost. 9/21/54</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip with osteomyelitis of the femur.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at the Wilmer Nursing Home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> p. m. <u>21</u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u>Nursing Home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury</u>		20f. (City or town) (County) (State) <u>Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> contributing.			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>6-26-56</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>June 27, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u>		24a. REC'D BY REGISTRAR <u>6-27-56</u>	
ADDRESS <u>Princess Anne, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>	

BUREAU V. S.

JUN 2 19

RECEIVED

6675

86662

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>May</u> Last <u>Jenkins</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1890</u>	9. AGE (In years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>	IF UNDER 24 HRS Hours <u>5</u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Minous Ruark</u>				14. MOTHER'S MAIDEN NAME <u>Belle Smullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records & Mr. Elisha W. Parker Jr (Son)</u> <u>E. State St. Delmar, Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Ca. metastasis of abdomen</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Inoperable Ca. of uterus</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease and diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 4, 1953</u> , to <u>June 9, 1956</u> , that I last saw the deceased alive on <u>June 9, 1956</u> , and that death occurred at <u>2:30 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Dr. V. Juerman</u> M.D. <u>Deer's Head State Hospital</u> <u>6/9/56</u> PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>6-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Kellum</u>	

MEDICAL CERTIFICATION

3 A 11111

10111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

16663

6676

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>RONALD</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>		4. DATE OF DEATH <u>June</u> <u>5</u> - <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 9, 1955</u>
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>5</u> Days <u>19</u> Hours <u>15</u> Min <u>00</u>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM FRAZIER JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>Luvenia Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Luvenia Johnson</u>		Address <u>Upper Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden death</u> DUE TO (b) <u>Pneumonia, Broncho</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CACTINISM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several wks.</u> <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 June</u> , 19 <u>56</u> , to <u>5 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>56</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris A. Lambdin</u> M.D. <u>707 Conder - Salisbury Md</u>		DATE SIGNED <u>June 5, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Morris A. Lambdin, Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-6-56</u>	22b. DATE THEREOF <u>6-6-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Upper Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Hill Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Johnson, Upper Hill, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 6-6-56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>

BUCKLEY M. S.

189

189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6797

CERTIFICATE OF DEATH

66664

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 Salisbury		d. STREET ADDRESS R.D.# 1 Salisbury	
3. NAME OF DECEASED (Type or print) First LILLIE Middle BELL Last JONES		4. DATE OF DEATH Month JUNE Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1872
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Work at Home	
11. BIRTHPLACE (State or foreign country) Shad Point (R.D.# Salisbury)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Williams		14. MOTHER'S MAIDEN NAME Charlotte Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. R.D.# 1 Salisbury, Maryland	
17. INFORMANT Mrs. Harold Townsend (Daughter) Address Shad Point		R.D.# 1 Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 to 6-5-1956 , that I last saw the deceased alive on 6-5-1956 and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley		ADDRESS (Street, city or town, state) East Main St. (Office) DATE SIGNED June 8 1956	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 9, 1956	22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery	22d. LOCATION (City, town, or county) (State) R.D.# 1 Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE 6-11-56	
24b. REGISTRAR'S SIGNATURE John J. ...			

S. A. GUTHRIE

1880

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6677 CERTIFICATE OF DEATH

66665

Reg. Dist. No. 222

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>2 days</u>		OR TOWN <u>Mardella</u> (Rural)		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Penninsula Gen Hosp</u>				Route <u>#3</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Walter</u> (Middle) <u>Lynch</u> (Last)				(Month) <u>6</u> (Day) <u>14</u> (Year) <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Unknown</u>	8. DATE OF BIRTH <u>About 1886</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>245 07 8050</u>		17. INFORMANT & ADDRESS <u>Wallet identification</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Hepatic Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of head of Pancreas</u>				<u>6 mos +</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/8</u> 19 <u>56</u> to <u>6/14</u> 19 <u>56</u> that I last saw the deceased alive on <u>6/14</u> 19 <u>56</u> and that death occurred at <u>3</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Walter S. Gardner, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>3215 D. St., Salisbury, Md.</u> DATE SIGNED <u>6/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>6-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hollister Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hollister, N.C.</u>	
24. REC'D BY REGISTRAR <u>J. F. Stewart</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary W. Stewart</u> ADDRESS <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>			

U. S.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06666

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mardela</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mardela</u> d. STREET ADDRESS <div style="text-align: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></div>			
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Albert</u> Middle <u>Malkin</u> Last			4. DATE OF DEATH <u>6-19</u> Month <u>19</u> Day <u>56</u> Year				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1906</u>	9. AGE (in years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Manfred Malkin</u>			14. MOTHER'S MAIDEN NAME <u>Bertha Rudie</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Harold Julien Malkin New York City, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Strangulation by hanging.</u> <u>1144</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="border: 1px solid black; padding: 5px;"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Scizophrenia</u> </div> <div style="border: 1px solid black; padding: 5px;"> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Hung himself in barn by the neck.</u> </div> <div style="border: 1px solid black; padding: 5px;"> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung himself in barn by the neck.</u> </div> <div style="border: 1px solid black; padding: 5px;"> 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> </div> <div style="border: 1px solid black; padding: 5px;"> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barn</u> </div> <div style="border: 1px solid black; padding: 5px;"> 20f. (City or town) <u>Mardela</u> (County) <u>Wicomico</u> (State) <u>Md.</u> </div>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>			DATE SIGNED <u>6-20-56</u>				
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>			
22d. LOCATION (City, town, or county) <u>Salisbury</u> (State) <u>MARYLAND</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas T. Walker, Salisbury, Md.</u>					
24a. REC'D BY REG-STRAR <u>6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

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BUREAU V. S.

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NIP



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6679

CERTIFICATE OF DEATH

06668

Reg. Dist. No. 382

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Route 1 - Box 177</u>			
3. NAME OF DECEASED (Type or print) First <u>Addison</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 4, 1925</u>	
9. AGE (In years last birthday) <u>31</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>F.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>BENJAMIN MITCHELL</u>			
14. MOTHER'S MAIDEN NAME <u>CORE LEE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>266-18-0388</u>				17. INFORMANT Address <u>Rosa Mitchell Pocomoke, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>High grade coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia due to urethral stricture, in remission</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-14</u> , 19 <u>56</u> , to <u>4-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>56</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Elliot</u> M.D. <u>Salisbury, Md.</u>				DATE SIGNED <u>4-19-56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar W. Horton</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-22-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

RECEIVED
JUN 23 1900
BUREAU H. A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6680

CERTIFICATE OF DEATH

Reg. Dist. No.

06669

332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS 221 South Blvd.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle HERBERT Last MOORE, SR.,		4. DATE OF DEATH Month June Day 16 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Chemical Eng.		10b. KIND OF BUSINESS OR INDUSTRY Engineer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U?S.A.	
13. FATHER'S NAME G.W. Moore		14. MOTHER'S MAIDEN NAME Lillian Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) —		16. SOCIAL SECURITY NO. 616-05- 8201	
17. INFORMANT 308 Beckford Ave.		Mrs. John L. Bond, Prince Anne, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Long use of diet food DUE TO (c) Generalized atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH months 5 days yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Henry A. Briele		M.D. Medical Center ADDRESS (Street, city or town, state) 6.18.56 DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Henry A. Briele, Medical Center, Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/56	
22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Norman T. Baker	
24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE Mary W. Hollonay	

8 1/2

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6681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>10 Mi.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Camden and Woodland Road</u>				d. STREET ADDRESS <u>224 East Church St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Bounds</u> Last <u>Niblett</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>X Female</u> <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1905</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Wm. Boundas</u>				14. MOTHER'S MAIDEN NAME <u>Belle Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>220-40-9812</u>		17. INFORMANT <u>Rudolph Niblett, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> <u>X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Deceased driving car involved in two car collision.</u>					
20c. TIME OF INJURY Month, Day, Year <u>9</u> <u>15</u> a.m. <u>6-14</u> <u>1956</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL, or other disposition <u>Burial</u>		22b. DATE THEREOF <u>6/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Siloan Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Siloan, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u> <u>Norman T. Baker</u>				24a. REC'D BY REGISTRAR <u>6-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

350

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6682

CERTIFICATE OF DEATH

Reg. Dist. No.

06671

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>RFD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mr. Howard</u> Middle <u>Patey</u> Last <u>Patey</u>				4. DATE OF DEATH Month <u>6/6/56</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1907</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Patey</u>				14. MOTHER'S MAIDEN NAME <u>Eva Patey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>xxxxxx</u>		16. SOCIAL SECURITY NUMBER <u>xxxx</u>		17. INFORMANT <u>Mrs. Martha Patey</u>		Address <u>Willards, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>6-6</u> , 19 <u>56</u> , and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-12-56</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/10/56</u>		<u>Mt. Pleasant Church</u>		<u>Willards Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Kelly</u>				24a. REC'D BY REGISTRAR DATE <u>6-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

8 A QUANTUM

1 N3



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b app: 30min.		d. STREET ADDRESS 812 East Church St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle ROBERT Last PHILLIPS		4. DATE OF DEATH Month June Day 28 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1944
9. AGE (in years last birthday) 11 yrs.		IF UNDER 1 YEAR: Months 9 Days 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Phillips		14. MOTHER'S MAIDEN NAME Wilsie Mae Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. James E. Phillips (Father)		Address 812 East Church St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 813x DUE TO (a), stating the underlying cause last. DUE TO</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 1 hour</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Riding bike and was involved in collision with road grader.	
20c. TIME OF INJURY Month, Day, Year 1:20 P.M. 6-28 1956		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXXXXX Street		20f. (City or town) Salisbury (County) Wicomico (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 29 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1956	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME- SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 2 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

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BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6684 CERTIFICATE OF DEATH

86673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wiconico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS In Village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIRGIE Middle MAE Last POWELL		4. DATE OF DEATH Month JUNE Day 22 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1902
9. AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months 7 Days 24	IF UNDER 24 HRS. Hours 8 Min 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY At own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Robert Bailey		14. MOTHER'S MAIDEN NAME Minnie Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. James W. Powell (Husband)	
17. INFORMANT Mr. James W. Powell (Husband)		Address Parsonsborg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) essential hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Week 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/18 , 19 56 , to 6/22 , 19 56 , that I last saw the deceased alive on 6/21 , 19 56 , and that death occurred at 5:40 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. (Office) DATE SIGNED June 22, 1956 ACTUAL SIGNATURE Dr. Earl Beardsley M.D. M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 24, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE FOLLOWAY & COMPANY FUNERAL HOME- SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE June 22, 1956 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. 8

JUN 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6799 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66674

Reg. Dist. No. 832

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> c. LENGTH OF STAY IN 1b <u>Federalsburg</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown bridge</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Quails Jr.</u>			4. DATE OF DEATH Month Day Year <u>6 16 19 56</u>										
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>About 1924</u>		9. AGE (In years last birthday) <u>32</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles Quails</u>										
14. MOTHER'S MAIDEN NAME <u>Tisia Collins</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)										
16. SOCIAL SECURITY NO. <u>216-18-2005</u>			17. INFORMANT Address <u>Ernest Quails, Seaford, Delaware, R.F.D.</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 204-A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drove car off open drawbridge at Sharptown through barricade.</u>													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>9 P 6-16-56 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>drawbridge Sharptown Wicomico Md.</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Earl L. Royer</u>			DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
EXAMINER'S NAME (Type) <u>Earl L. Royer M.D.</u>			<u>6-16-56</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>									
22d. LOCATION (City, town, or county) <u>Federalsburg, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.J. Frempton and Son, Federalsburg, Maryland</u>											
24a. REC'D BY REGISTRAR <u>DATE 6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3 A 172-100

9. 1. 10. NR!

10. 1. 10. NR!

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6685

CERTIFICATE OF DEATH

06675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS In Village	
3. NAME OF DECEASED (Type or print) First CORA Middle CAROLINE Last RAYNE		4. DATE OF DEATH Month JUNE Day 5 Year th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1874
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months 11 Days 20 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Work		10b. KIND OF BUSINESS OR INDUSTRY House Work	
11. BIRTHPLACE (State or foreign country) R.D.# Snow Hill Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Jones		14. MOTHER'S MAIDEN NAME Sarah Grace Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Harry Rayne (Son) Willards, Maryland Mr. Lester Rayne (Son) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO CEREBRO VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (c) YEARS			INTERVAL BETWEEN ONSET AND DEATH 1 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/10/1954 to 6/5/1956 , that I last saw the deceased alive on 6/4/1956 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. -Office- DATE SIGNED June 5 1956			
ACTUAL SIGNATURE Dr. O.J. Burton M.D.		M.D. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 7, 1956	22c. NAME OF CEMETERY OR CREMATORY Pleasant Mt. Pleasant Cemetery	22d. LOCATION (City, town, or county) (State) R.D.# Powellville, Maryland R.D.# Willards, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JUN 6 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

U.S. AIR FORCE

OFFICE OF THE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6710

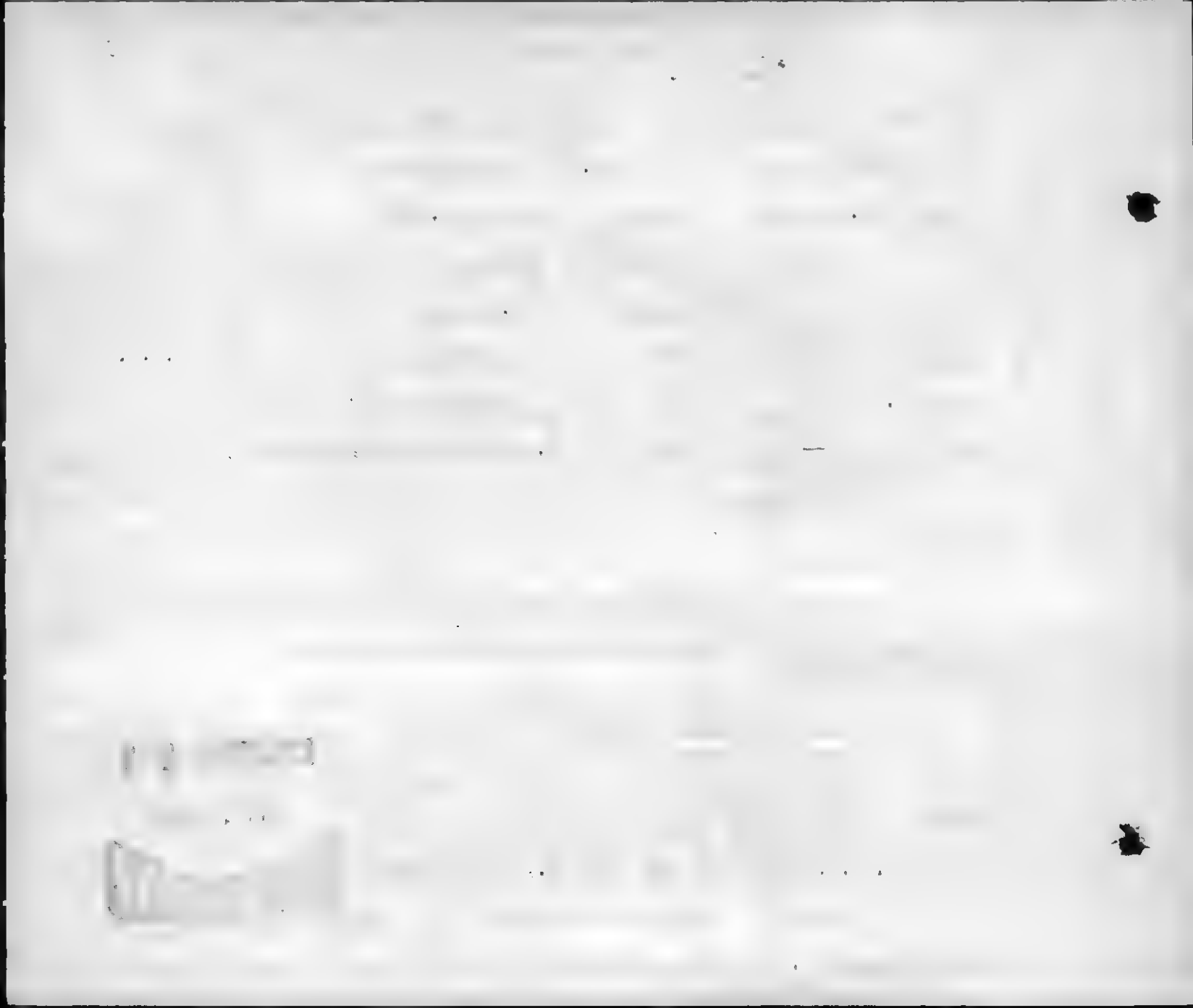
CERTIFICATE OF DEATH

06676

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg c. LENGTH OF STAY IN 1b 91 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #1				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg d. STREET ADDRESS Rt. #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIJAH QUINTON RILEY				4. DATE OF DEATH Month Day Year 6 13 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1864	
9. AGE (In years last birthday) 91 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James D. Riley			
14. MOTHER'S MAIDEN NAME Hannah Bethard				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Mrs. Howard Johnson, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 31 DUE TO Cerebral arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic pneumonia R. + L.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Salisbury		20h. (State) Maryland	
21. I certify that I attended the deceased from 1953 to 6-11 , 19 56 , that I last saw the deceased alive on 6-11 , 19 56 , and that death occurred at 11 45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/1/56							
ACTUAL SIGNATURE [Signature] M.D. [Signature]							
PHYSICIAN'S NAME (Type) Dr. L.V. Sohler 303 East St., Delmar Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/56		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland Norman T. Baker				24a. REC'D BY REGISTRAR DATE 6-14-56		24b. REGISTRAR'S SIGNATURE Mary W. Holliday	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06677

6686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Adams Park</u>			
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Roberts</u> Last <u>Roberts</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1938</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Elmore Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Stansbury</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 11, 1955</u> , to <u>June 24, 1956</u> , that I last saw the deceased alive on <u>June 24, 1956</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>6/24/56</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>L. V. Maldve, M.D.</u> NAME (Type) <u>L. V. Maldve, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. DUNGE

1864

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 882

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 831 Cooper St		d. STREET ADDRESS 831 Cooper St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First META Middle CLARICE Last SHOCKLEY		4. DATE OF DEATH Month JUNE Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1896
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own home	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Grant Bedsworth		14. MOTHER'S MAIDEN NAME Isabelle Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Ira O. Shockley (Husband)		Address 831 Cooper St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 40.4.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 19 52 to 6/14 1956 , that I last saw the deceased alive on 6/14/56 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St DATE SIGNED June 17 1956			
ACTUAL SIGNATURE Fred R. Gramse M.D.		DATE SIGNED June 17 1956	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 17, 1956	22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME		ADDRESS SALISBURY, MD.	
24a. REC'D BY REGISTRAR DATE 6-19-56		24b. REGISTRAR'S SIGNATURE May W. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6689

CERTIFICATE OF DEATH

66679

Reg. Dist. No. 222

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELEWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>RD #1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN NMI SPARKS</u>				4. DATE OF DEATH Month Day Year <u>JUNE 9 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 5, 1915</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM REESE SPARKS</u>		14. MOTHER'S MAIDEN NAME <u>ETTA SARAH LOVELACE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS ROSE S. BROWN—</u> Address <u>FEDERALS BURG MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brain Abscess</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>6/7</u> , 19 <u>56</u> , to <u>6/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>56</u> , and that death occurred at <u>11:47 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>234 N. Division St. Salisbury, Md.</u>			
DATE SIGNED <u>6/11/56</u>							
PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALS BURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MEDFORD L. WATSON JR.</u>				ADDRESS <u>SEAFORD, DELAWARE</u>		24a. REC'D BY REGISTRAR DATE <u>6-13-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>			

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6688
11-7-56 et
CERTIFICATE OF DEATH

17723

Reg. Dist. No. 331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>SPRIEL</u> Last <u>SPRIEL</u>			4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>55 Yrs</u> <u>1899</u> <u>May 31</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Norfolk, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Wallace</u>			14. MOTHER'S MAIDEN NAME <u>Georgie Dennis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>249-34-2945</u>	17. INFORMANT <u>Helen Halbrook</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shamion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ovarian Carcinoma</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Ostorne Christensen</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Ostorne Christensen</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>	<u>1-21-56</u>	<u>Green Acres Cem</u>		<u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. 718 Hunt</u>		ADDRESS <u>Salisbury</u>		24a. REC'D BY REGISTRAR DATE <u>7-5-56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Halbrook</u>

BUREAU V. S.

SEP 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6690

CERTIFICATE OF DEATH

Reg. Dist. No. 00880

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN It 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Alice Last Stafford		4. DATE OF DEATH Month June Day 12 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1876
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Pratt		14. MOTHER'S MAIDEN NAME Sirena Anne Dukes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5-6 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 11, 1956 , to June 12, 1956 , that I last saw the deceased alive on June 12, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 6/12/56	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE 6/15/56		Don O'Grady	

BURKE, J. A. S.

1000 (2) 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6691 CERTIFICATE OF DEATH

Reg. Dist. No. 222

66681

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R. 7. D #2.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donnell Stevenson</u>				4. DATE OF DEATH Month Day Year <u>June 9 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7-1956</u>	9. AGE (In years last birthday) yrs. Months Days <u>46</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Kendal Price</u>			
14. MOTHER'S MAIDEN NAME <u>BARBARA Lee STEVENSON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>BARBARA STEVENSON</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Altelectasia, bilateral</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exposure (delivered in car 20 mi from hospital) Traumatic death</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Delivery</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 p.m.</u> , 19 <u>56</u> , to <u>9 p.m.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 June</u> , 19 <u>56</u> , and that death occurred at <u>12 noon</u> , M, from the causes and on the date stated above.							
ACTUAL <u>Robert G. Henderson</u> M.D.				ADDRESS (Street, city or town, state) <u>926 N. Division St. Salisbury</u>			
DATE SIGNED <u>11 June 56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>							
22b. DATE THEREOF <u>11/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

S. A. LIVING

JUN 13 1966



6692

CERTIFICATE OF DEATH

06682

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNT Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (In this place) 2 months		CITY (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) Beckford Ave			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Rachel (Middle) Done (Last) Stewart				(Month) June (Day) 9 (Year) 19 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH April 7, 1870	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Princess Anne, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr. William Stewart				14. MOTHER'S MAIDEN NAME Henrietta Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mrs. Mary D. Fitzgerald			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) _____				Carcinoma Colon			
ANTECEDENT CAUSE(S) DUE TO _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 8, 1956 , to June 9, 1956 , that I last saw the deceased alive on June 8, 1956 , and that death occurred at 10:15 AM , from the causes and on the date stated above.							
SIGNATURE Theresa Lush		M.D. Salisbury Md		ADDRESS (Street, city, town, state) Princess Anne, Md		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 11, 1956		NAME OF CEMETERY OR CREMATORY St. Andrews Cemetery		LOCATION (City, town, or county) (State) Princess Anne, Maryland	
24. REC'D BY REGISTRAR DATE 6-20-56		REGISTRAR'S SIGNATURE Mary W. Hollenray		25. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson		ADDRESS Princess Anne, Md	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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6693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 year s</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>Patrick Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>James</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1923</u>	9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Delmar md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Regero Taylor</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-12-1444</u>		17. INFORMANT Address <u>Hospital Record, P.G.H. Salisbury Md.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage into Pericardial and Pleural Cavities</u> DUE TO <u>105 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stab wound of Pulmonary Artery</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Kendrick Mc Cullough</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Kendrick Mc Cullough, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>6-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Delmar Cem</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. J. M. McCreed</u>				22d. LOCATION (City, town, or county) <u>Delmar md</u>		(State) <u> </u>	
23a. REC'D BY REGISTRAR <u>6-9-56</u>				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8 A OCT 1964

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6711

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. # 1 (Union Rd)</u>				d. STREET ADDRESS <u>R.D. # 1 (Union Rd)</u>			
3. NAME OF DECEASED (Type or print) First <u>OLGA</u> Middle <u>ROSE</u> Last <u>THEODORE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1986</u>	9. AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Danzig, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME (Unk) <u>Mitush</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Nicholas Theodore (Husband)</u> Address <u>R.D. # 1 Union Rd Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 1, 1956</u> to <u>June 20, 1956</u> that I last saw the deceased alive on <u>6-18-56</u> and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lee Lawry M.D.</u> M.D.				ADDRESS (Street, city, town, state) <u>Fruitland</u> DATE SIGNED <u>June 20 1956</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Lee Lawry M.D.</u>				<u>Fruitland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME- SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 6-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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EDWARD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6694

CERTIFICATE OF DEATH

Reg. Dist. No.

06685
322

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 518 E. Isabella St		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3. NAME OF DECEASED (Type or print) First ANELA Middle BURKE Last THURSTON		4. DATE OF DEATH Month JUNE Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1868
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Retired House Keeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Chastine F. Coleman		14. MOTHER'S MAIDEN NAME Julia Jordan	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Walter C. Thurston Jr. (Son)		Address 518 E. Isabella St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis H.S.O.O. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-14-1955 to 6-14-1956 that I last saw the deceased alive on 6-14-1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. David J. Gilmore M.D. Medical Center June 15 1956 Dr. Wilber Ellis M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF June 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY Churchland Cemetery		22d. LOCATION (City, town, or county) (State) Near Portsmouth, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY MD.		24a. REC'D BY REGISTRAR DATE 6-18-56	
24b. REGISTRAR'S SIGNATURE May W. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6695
CERTIFICATE OF DEATH

06686

Reg. Dist. No. **332**

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home 409 Camden Court				d. STREET ADDRESS W. Central Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J. Frank Middle Todd Last				4. DATE OF DEATH Month June Day 18 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1861		9. AGE (In years last birthday) 95 yrs	IF UNDER 1 YEAR Months Days Hours Mins.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer & merchant			10b. KIND OF BUSINESS OR INDUSTRY Caroline Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Jehu Todd				14. MOTHER'S MAIDEN NAME Henryetta Sutherland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Louise F. Todd Federalsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14 , 19 56 , to 6/18 , 19 56 , that I last saw the deceased alive on 6/18 , 19 56 , and that death occurred at 9:30 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. R. Gramse				ADDRESS (Street, city or town, state) Salisbury, Md.			
PHYSICIAN'S NAME (Type) Fred R. Gramse, M.D.				DATE SIGNED 6-21-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		22d. LOCATION (City, town, or county) (State) Federalsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams				ADDRESS Federalsburg, Md.		24a. REC'D BY REGISTRAR DATE 6-25-56	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloman			

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NOV 1 1966

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06687

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u> d. STREET ADDRESS <u>RFD</u> e. IS RESIDENCE <input type="checkbox"/> ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rufus</u>		First <u>Rufus</u> Middle <u>Truitt</u> Last <u>Truitt</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9 1924</u>		9. AGE (In years last birthday) <u>32</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of last year, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				13. FATHER'S NAME <u>James R. Truitt</u>			
14. MOTHER'S MAIDEN NAME <u>Mildred V. Bradford</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <input checked="" type="checkbox"/> unknown) <u>X</u>			
16. SOCIAL SECURITY NO. <u>218-16-5755</u>		17. INFORMANT <u>James R. Truitt</u> Address <u>Willards, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of cervical spine</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased was driving car that struck a culvert RFD # 374</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6-10</u> a. m. <u>19 56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> 20f. (City or town) (County) (State) <u>near Berlin</u> <u>Wicomico</u> <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>		EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>6-15-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>			
22d. LOCATION (City, town, or county) (State) <u>Willards</u> <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>					
24a. REC'D BY REGISTRAR <u>6-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

A34

31.12.1950

CERTIFICATE OF DEATH

6712

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Nanticoke</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		TOWN <u>Nanticoke</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lucy</u> (Middle) <u>Jane</u> (Last) <u>Walter</u>				(Month) <u>June</u> (Day) <u>16</u> (Year) <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 3, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months <u>10</u> Days <u>13</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Demonstration Agent (Extension service)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Nanticoke, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Levin Thomas Walter</u>				14. MOTHER'S MAIDEN NAME <u>Emily S. Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Levin Walter, Nanticoke, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Ischemic Heart Disease</u>				SYNOPSIS <u>5 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5:15</u> , 19 <u>56</u> , to <u>6:11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/16</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city, town, state) <u>Nanticoke, MD</u>		DATE SIGNED <u>6/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Traskin, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary N. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messitt</u>		ADDRESS <u>Bivalve, Maryland</u>	
DATE <u>6-22-56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The before copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate must be detached for use as a burial transit permit.

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BUREAU V. E.

1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6697

CERTIFICATE OF DEATH

66689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.R. #2</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth F. Waters</u>				4. DATE OF DEATH <u>June 22-1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13-1956</u>		9. AGE (In years last birthday) <u>1</u> yrs. <u>11</u> months <u>11</u> days <u>11</u> min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edward Walters</u>				14. MOTHER'S MAIDEN NAME <u>Delosier Yancey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Edward Walters</u> Address <u>Pocomoke Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lower Nephron Nephrosis</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-19-1956</u> to <u>6-22-1956</u> that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris C. Lambdin</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson</u> ADDRESS <u>Pocomoke Md</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

RECEIVED

JUN 25 1956

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66980
(06690)
332
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sandy Hill Beach</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>RFD #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman Whaley</u>				4. DATE OF DEATH Month Day Year <u>6 17 19 56</u>															
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12 1928</u>		9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner Home Heating Oil</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>				11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Whaley</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hudson Whaley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES <input type="checkbox"/> NO <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>22965 2242 2242</u>				17. INFORMANT <u>Agnes Whaley Salisbury Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Found floundering in water face down at Sandy Hill Beach.</u>															
20c. TIME OF INJURY Hour Month, Day, Year <u>4:45 a.m. 6-17-19 5</u>				20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beach</u>				20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined cause</u> <input type="checkbox"/>																			
SIGNATURE <u>Earl L. Royer</u> M.D. EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-20-56</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-20-56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Delaware</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson + Gray Frankford Del.</u>				24a. REC'D BY REGISTRAR <u>DATE 6-20-56</u>				24b. REGISTRAR'S SIGNATURE <u>Mary W. McElroy</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

JUN 28 1988

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6699

CERTIFICATE OF DEATH

66691

Reg. Dist. No.

332.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? - YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle <u>ELLEN</u> Last <u>Waller</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10, 1885</u>		9. AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WICOMICO CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY HUTT</u>				14. MOTHER'S MAIDEN NAME <u>HENNIE (MAIDEN NAME UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>MRS. CATHERINE THOMAS - MARDELA, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1956</u> , to <u>June 29, 1956</u> , that I last saw the deceased alive on <u>June 29, 1956</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL <u>Andrew C. Mitchell</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>6-29-56</u>	
PHYSICIAN'S NAME (Type) <u>ANDREW C. Mitchell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. NEBO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR DELMAR, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u> ADDRESS <u>Box, Federalburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>Maryell Holloway</u>	

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06692

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finchville</u>		d. STREET ADDRESS 			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown drawbridge</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles</u> <u>Henry</u> <u>Williams Jr.</u>				4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>19 56</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22, 1949</u>			
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles H. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lee Tilghman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles H. Williams, Federalsburg, Md.</u> R.F.D.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in car that ran off open drawbridge through barricade.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9 P</u> o. m. <u>6-16</u> p. m. <u>19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Drawbridge</u>		20f. (City or town) <u>Sharptown</u> (County) <u>Wicomico</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.									
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DATE SIGNED <u>6-18-56</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Federalsburg, Maryland</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR <u>6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Halloway</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Handwritten signature or scribble.

5714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		c. LENGTH OF STAY IN 1b <u>Finchville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown drawbridge</u>		d. STREET ADDRESS <u>Finchville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Lee Williams</u>		4. DATE OF DEATH Month Day Year <u>3-16-1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1914</u>
9. AGE (in years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>42</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Tilghman</u>		14. MOTHER'S MAIDEN NAME <u>Rosealee Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Charles H. Williams, Federalsburg, Md.</u>		Address <u>R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>Sudden</u> DUE TO (c) <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that went through barricade of open drawbridge.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9 P. M. 6-16 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sharptown drawbridge. Sharptown Wicomico Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		ADDRESS <u>Federalsburg, Maryland</u>	
24a. REC'D BY REGISTRAR <u>6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral par. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06694

67-0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9, Film 6-22-56 et

Reg. Dist. No.

776 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deers Head Hospital</u>				d. STREET ADDRESS <u>Deers Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Lee</u> Last <u>Wrightson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>M</u> <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1894</u>	
9. AGE (In years last birthday) <u>62 6/7</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cambridge</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>J. Alonza Wrightson</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Ewell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Helen Jones, 112 Cemetery Ave., Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>223X</u> IMMEDIATE CAUSE (a) <u>Edema of lungs and brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Neurofibroma of cerebellum</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Months</u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>6-14-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel R. Jones</u> ADDRESS <u>Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>June 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. S.</u>	

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STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINERS - CERTIFICATE OF DEATH

BUREAU V. S.

JUN 13 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low require that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pay the funeral director, page 3, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6701

CERTIFICATE OF DEATH

Reg. Dist. No.

06695

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Brooklyn Ave		d. STREET ADDRESS 113 Brooklyn Ave.	
3. NAME OF DECEASED (Type or print) CHARLES RUSSELL YOHE		4. DATE OF DEATH Month JUNE Day 15 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1900
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician (Piano-Organ)		10b. KIND OF BUSINESS OR INDUSTRY W.B.O.C. Worked Radio-T.V.	
11. BIRTHPLACE (State or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Yohe		14. MOTHER'S MAIDEN NAME Etha Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Claudia Yohe (Wife)		Address 113 Brooklyn Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compensated - Heart (c)			INTERVAL BETWEEN ONSET AND DEATH sudden 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 14, 1956 to June 15, 1956 , that I last saw the deceased alive on June 14, 1956 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Gray		ADDRESS (Street, city or town, state) 334 Camden Ave. (Office) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. William D. Gray M.D.		DATE SIGNED June 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 18, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 6-19-56	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Occupation		Cause of Death		Date of Death		Place of Death		Time of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist	
Signature of Nurse		Signature of Undertaker		Signature of Burial Place		Signature of Cemetery		Signature of Funeral Home	

BUREAU V. S.

JUN 19 1956

RECEIVED